

Male Suicide

*Why aren't men seeking help?
What can we do about it?*

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Warnings & ground-rules

1. Wanting to promote the understanding of one gender does not imply a lack of concern for the other – specialising in children does not mean you hate old people!
2. Understanding *both* genders and gender as a system creates a better chance of helping humanity as a whole – lack of male gender study is bad for all
3. Gender is very emotive but then so is psychology! This talk is therefore given with the greatest respect for female gender issues and inequalities which also need to be tackled where they exist
4. Exploring gender difference does not deny the common humanity of male and female but does honour human diversity
5. Gender is not just an equality issue but also a diversity issue

Suicide – A Big Killer, so surely a Big Public Health Issue ?!

- ▶ In the UK suicide (using ONS figures for 2013) is the **most common cause of death** for:
 - (a) men aged 20–49 years old
 - (b) women aged 20–34
- ▶ Suicide is the **second most common cause of death** for teenage males (6th for females)
- ▶ Public Health England Strategic plan 2016–20: suicide and mental health are mentioned only once and then only in connection with the NHS, not as a headline issue – gender not at all!

Blindness Number One – “Mind Blindness”

- ▶ Our whole culture of health science, policy, research, funding, service provision and intervention is split, focusing on the **body** and largely ignoring the mind (reducing it to the brain – “all in the mind” means not REAL, second class, not HARD evidence!)
- ▶ Mental health is only referred to in medicalised terms as a set of “disorders” and is not normalised as a global part of the human condition, thus reinforcing stigma
- ▶ The underlying assumption is that healthy living is mainly about diet, behaviour and lifestyle – there is no curiosity in public health terms about the “inner world” of people or the generic psychological and interpersonal causes of good and bad mental health, so suicide is seen as a symptom of an externalised “mental illness” rather than as a reflection of the psychological pain inherent in the trials and tribulations of the human condition

Consequences of Mind-Blindness

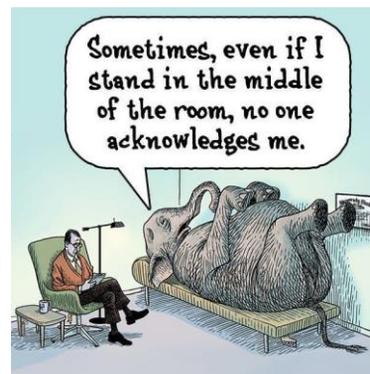
- Public policy ignores child-adult attachments, love, empathy and relationships, trauma, abuse and neglect in the development of mental health problems
- Public policy ignores the vital role of attachments, empathy and relationships (trauma, abuse, bullying, neglect) in schools
- Public policy ignores the central importance of attachments, empathy and relationships between providers and receivers of care in the health care system (re-traumatising, neglect) – the “evidence-base” is medicalised and depersonalised
- Public policy ignores the personal and social *meaning and worth* that people *subjectively* feel their lives to have (low self-esteem is seen as symptom of depression, not cause) – the impact of gender on the meaning of experience is therefore equally disregarded
- Public health policy is in effect unempathic, depersonalised, medicalised, de-contextualised and *emotionally illiterate*

Suicide & Other Troubles of the Male Gender – the Stark Statistics

- Males account for the *vast majority* of suicides in *every age group, in every country/culture (bar one)* and at *every point in history* since records began (1861 in UK) (see WHO for list)
- 78% of suicides in UK (2013, ONS)
- 97% deaths at work (2009–14, HSE)
- 75% of drug and alcohol addiction (2009, NHS)
- 85% of rough sleeping (2015–6, London UK)
- 95% prison population (2016, UK)
- University admissions 58,000 or 22% less for males (2014, UK)
- Lower life expectancy by 4 years UK (2013, WHO)

Blindness Number Two – Male Gender Blindness

- All of the above statistics are ignored completely in public policy and strategy towards the well-being of citizens even though half are male gender
- The big picture (“elephant in the room”) on men is never put together from the elements
- The assumption is that only the female gender can be vulnerable or carry disadvantages (e.g. even *male suffrage* ignored)
- There is even a ministry in the UK called “women and inequalities” as if the two were synonymous
- We are more tolerant of risk and harm to adult males and less sympathetic to the idea of a vulnerable adult male than a vulnerable woman or child (“women and children first”)



Two biggest causes of male gender blindness

- ▶ A gender narrative that focuses exclusively on female disadvantage has become mainstream, creating a pseudo-scientific and political paradigm that dominates all our public thinking
- ▶ Male archetypes in the human species are about strength and protection of the social group (fighting, defending, hunting, providing, protecting, mastery and control) and so men are under evolutionary pressure to provide protection (especially for women and children) not to seek it and society as a whole has evolved to see the male as less sympathetic, more expendable and more disposable – there to “take the bullet”

So male mental health is the biggest taboo ever!

- ▶ Male mental health (including even suicide) therefore is the biggest taboo (double stigma) ever because it offends against 4 massive principles:
 - ▶ (A) The male archetype – a man should provide protection (especially for women and children) not require it himself
 - ▶ (B) The *women victim only* narrative – men are privileged and powerful – only women can suffer gender disadvantage and inequality – so only women need gender-based help
 - ▶ (C) mind-blindness – depression is a “mental illness” based in our brain-chemistry so there can be no gender differences or issues in relation to the *meaning of suicide*
 - ▶ (D) Stigma – asking for help for mental health makes you different from the majority, one of “them” (1 in 4) not “us” (3 in 4)

Addressing male suicide cannot begin without recognising it as a gender issue

- ▶ Even when male suicide stares us in the face we hardly see it
- ▶ So when it comes to men, we have to start looking at the wood, not the trees – suicide is a symptom of an even bigger picture regarding our attitudes to the male
- ▶ There is some change in public attitudes but it is slow and encountering massive resistance both conscious and unconscious
- ▶ By coming to this talk you are electing to be part of the change – thank you!

Two Fundamental Choices

- ▶ If we want to reduce male suicide we have to choose primarily one of the following options:
 - ▶ (A) Change men and masculinity itself (start talking and opening up! Open men’s hearts to society!)
 - ▶ OR
 - ▶ (B) Change society’s attitudes and responses to men (start listening and caring! Open the hearts of society to men!)

So far we are mainly making the wrong choice!

- ▶ Society, including even mental health charities and certainly the media, is nearly always going for option “(A)”
- ▶ Option “(A)” boils down to:
 - ▶ *“Guys, you are emotionally illiterate and too macho – you need to open up, share feelings, soften up and come out of the dark ages of “patriarchy” and “hegemony” – be more like women and use the great help that is already there for you!”*

Why Option “(A)” can’t work

- ▶ Bad Science – confuses nature with nurture and ignores biology and evolution – dismisses differences – society is being emotionally illiterate, not men
- ▶ Confuses stereotypes (social constructs) with archetypes (evolved instincts e.g. maternal, protective)
- ▶ Victim-blaming – how many messages for other social groups in distress are this judgmental and chiding?
- ▶ Reinforces the bad attitudes to masculinity that increase suicide risk in the first place!
- ▶ Double-message with all the other signals being given to men e.g. “keep taking risks at work guys, that’s your job!” (see above)

The ultimate double-bind!

- ▶ **Message 1** – open up, talk, share your feelings! (we care!)
- VS.
- ▶ **Message 2** – don’t expect any sympathy – we are not really listening to or protective of males! (we don’t care!)

Making Option “(B)” work

- ▶ The rest of this talk is about option “(B)” and how to make it work for men and for society as a whole
- ▶ If you don’t believe in option “(B)” look away now!
- ▶ Option “(B)” boils down to *let’s respect differences, tune in to male needs and communication styles and adapt services to suit them rather than trying to neutralise or “de-masculinise” males*

Option B in a Nutshell

- ▶ Men are not emotionally *ill*iterate, they are ***differently*** literate
- ▶ Difference should be respected and honoured to connect with any human being or indeed any sentient being
- ▶ Men have different ways of showing, communicating and responding to distress – why not offer services that take account of that?
- ▶ If we don't do that surely we are failing in our duty of care to a group that is clearly at risk and on whom other lives (of both genders) depend?

Toxic attitudes to Masculinity 1

- ▶ Blindly confusing extreme, damaged and macho behaviour of some males with masculinity as a whole (which is a spectrum with an average that is not macho)
- ▶ Bad men seen as typical rather than exceptional so "rape culture" becomes mainstream concept (see media and public responses to incidents by damaged men – e.g. India Chipchase – rapist *not the loving dad* ("*I'll never walk my daughter down the aisle*") is seen as the norm – so we are told we must "educate" *all boys* to respect girls – masculinity = rape: look boys, you are all potential rapists, not potential loving dads!)
- ▶ Blaming the male gender itself, not the emotional damage for the gendered way males respond to emotional damage (see prison population, mainly mentally damaged men)

Toxic Attitudes 2

- ▶ The Cambridge Union debate (May 2016) – "This House believes that masculinity is harmful for everyone" – the motion was carried!
- ▶ Permissible and tolerated sexism and misogyny e.g. Leadsom on *all* men as potential paedophiles (no action, reaction) vs. professor Tim Hunt making observations on gender differences and relations in laboratories (resigns job, public outcry)
- ▶ Grayson Perry (Alpha Male) used as a reason to attack masculinity rather than as an example of its variability
- ▶ Good stuff (e.g. protecting, providing) that men do for society everyday and through history is denied, disregarded and ignored – Titanic, WW1 WW2etc.
- ▶ Male suffering and sacrifice played down, airbrushed out

Society can't succeed with these toxic beliefs and attitudes

- ▶ Services are not respecting, but actually dishonouring masculinity and male gender differences
- ▶ Any other group (age, disability, religion, culture) would receive tailored services, not pressure to change to fit the service
- ▶ Standard or generic mental health and counselling services are more suited to typical female patterns of emotional behaviour or even "feminised" (Linda Morison et al, 2014)

Positive evidence that male-specific services can and do work

- ▶ Campaign against Living Miserably (CALM)
- ▶ “Man Talk” Central London Samaritans (2014)
- ▶ Eaton Foundation
- ▶ Men’s Sheds
- ▶ Men’s groups
- ▶ Sport-related projects
- ▶ Barbers and hairdressers
- ▶ Military and veteran PTSD models
- ▶ Other examples – please tell us

What would a male-friendly service look like?

- ▶ Early days but based on the evidence so far:
- ▶ Needs to depart from the mainstream “feminised” assumptions of the “counselling world”
- ▶ Involves no immediate pressure to express feelings directly in words face to face
- ▶ Focuses on “story” more than “feelings”
- ▶ Honours “banter” as an attempt to build a connection rather than an avoidance of connection
- ▶ Uses male camaraderie and enables men to bond in non-verbal ways

Male-Friendly Services 2

- ▶ Uses activities that appeal to men
- ▶ Creates spaces where men can feel validated and honoured rather than shamed
- ▶ Uses male archetypes rather than trying to deconstruct them
- ▶ Emphasises getting alongside more than getting inside
- ▶ Offers help that honours male archetypes rather than undermining them *e.g.* “**seeking help can be framed as **taking control**” or “**taking action**” (strength) as opposed to “**letting yourself be vulnerable**” (weakness)**

Male Psychology Network
Promoting the Wellbeing of Men and Boys



Home The Network Male Psychology Conference Events



<http://www.malepsychology.org.uk/>

Male Psychology Network

- ▶ Voluntary organisation, began 2011
 - 40 members, ~30% women
 - Psychologists, therapists, students, charity workers
- ▶ Campaigning for a Male Psychology Section of the British Psychological Society
- ▶ Annual conference at UCL (23–24 June, 2017)
- ▶ Special issue of *New Male Studies*, Dec 2016
 - <http://newmalestudies.com/OJS/index.php/nms>
- ▶ Forthcoming *Handbook of Male Psychology*
- ▶ New website
- ▶ Research projects & publications

Publications (2014–present)

- ▶ Martin Seager, John Barry & Luke Sullivan (2016). [Challenging male gender blindness – why psychologists should be leading the way](#). *Clinical Psychology Forum*
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- ▶ Russ, S., Ellam-Dyson, V., & Seager, M. & Barry, J. A. (2015). [Coaches' views on differences in treatment style for male and female clients](#). *New Male Studies*, 4(3), 75–92.
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- ▶ Kingierlee, R., Precious, D., Sullivan, L., & Barry, J. A. (2014). [Engaging with the emotional lives of men: designing and promoting male-specific services and interventions](#). *The Psychologist*, June edition
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<http://www.malepsychology.org.uk/research-library/>

Research

- ▶ **Addressing questions such as:**
- ▶ Is suicidality related to gender-typical thinking?
- ▶ Do men and women respond differently to different techniques and approaches?
- ▶ Do men prefer different types of therapies to the ones women like?
- ▶ If men don't go to therapy, what do they do to relieve stress?

Is suicidality related to gender-typical thinking?

- ▶ Seager, Sullivan & Barry (2014)
- ▶ 348 women, 170 men, online survey
- ▶ Factor analysis of traditional gender-script questionnaires
- ▶ Multiple linear hierarchical regression found:
- ▶ Two male gender subscales predicted risk of suicidality
 - *Fight & Win* ($P < .001$); *Mastery & Control* ($P < .042$)
- ▶ One female gender subscale predicted reduced risk of suicidality
 - *Family Harmony* ($P < .003$)
- ▶ Replication by Middleton-Curran, Seager, Brown & Barry (in preparation)

Do therapists say men and women have different needs from therapy?

- ▶ Semi-structured interviews; grounded theory
- ▶ 20 life coaches (Russ et al, 2015)
 - 90% reported sex difference in client needs
 - 65% of coaches demonstrated ambivalence to making generalisations about gender
- ▶ 6 hypnotherapists (Lemkey et al, 2016)
 - 100% reported sex differences in client needs
- ▶ 20 clinical psychologists, psychotherapists and counsellors (Holloway et al, in preparation)
 - 100% reported sex difference in client needs
 - Men want quick fix; women want to explore feelings
 - 80% showed ambivalence to making generalisations about gender

Male gender blindness

- ▶ Common theme in Russ et al (2015) & Holloway et al (in preparation) of identifying sex differences, but with ambivalence
 - *"I hate generalising, but men prefer X & women prefer Y"*
- ▶ Cognitive dissonance (Festinger, 1962)
- ▶ Beta-bias (Hare-Mustin & Marecek, 1988)
- ▶ Gender similarity hypothesis (Hyde, 2005)
 - 'More similarities than differences'
 - Says we should recognise moderate differences, but does not do so herself for mental rotation ability
 - Does not include toy preference ($d = 1.05$ for boy toys) (Todd, Fischer, Greene, diCosta & Barry, in preparation).
- ▶ Narrative leads to *male gender blindness* (Seager et al, 2014) and the *gender empathy gap* (Bradford, 2015; Barry, 2016)

How much do men and women like various types of therapy?

- ▶ Online survey (Liddon et al, in preparation)
- ▶ 115 men, 232 women (mean \pm SD age 36 \pm 14.2)
- ▶ *If you had a mental health problem, what kind of treatment would you prefer?*
 - Strongly like = 6; Strongly dislike = 1
- ▶ Regression controlling for *gender, Age, Ethnicity, from a Westernised country, Educational status, Occupational status, Marital status, Income, Relied on by others, and Whether have had therapy before*

Sex differences related to therapy

- ▶ In ~20% of the variables assessed, sex differences were found in preferences for therapy, coping styles, and help-seeking behaviour e.g.
 - Men liked support groups more than women did
 - Men used sex to cope with stress more than women did
 - Men thought male-friendly treatment options were not available more than women did

Do people want a male therapist?

	Men (n = 109)	Women (n = 207)
No preference	62% (67)	61% (133)
Prefer female therapist	22% (24)	34% (74)
Prefer male therapist	17% (18)	5% (10)

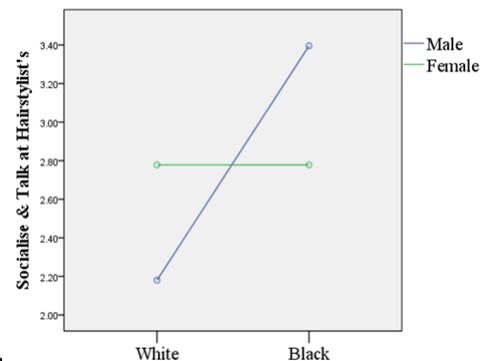
Data from Liddon et al (in preparation)

If men don't go to therapy, what do they do to relieve stress?

- ▶ Should we be looking more at everyday activities as sources of mental health
 - Behavioural activation therapy (Jacobsen et al, 2001)
 - Pub (Emslie et al, 2013)
 - *Men's Sheds*
 - Chatting with barber
 - *'Is having a haircut good for your mental health?'*

Everyday sources of wellbeing

- ▶ Men, especially Afro Caribbean, are less likely than women to seek help for mental health issues (Powell & Barry, cited 2014 in Seager et al, 2014b)
- ▶ Barber shops are often places of lively chat for black men
 - possibly supportive of mental health?
- ▶ Survey of 149 white and 53 black people on opinions re visiting hair stylist (Roper & Barry, in press)
- ▶ Controlling for age, black men socialised and talked at the hair stylist significantly more than white men or black or white women ($p < .01$)
 - Talk was about health &/or personal issues



Conclusions

- ▶ Male gender blindness prevents us from addressing male psychological health issues
- ▶ Psychologists suffer from this probably just as much as anyone else
- ▶ What can each of us do to reduce gender blindness and male suicide?
 - ▶ **Let's make *International Men's Day* a focus for making a positive difference**

International Men's Day

- ▶ House of Commons debate pack for debate today on International Men's Day
- ▶ <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CDP-2016-0207#fullreport>
- ▶ The full debate pack can be downloaded from the above link – all the evidence is in one place

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